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# COMPREHENSIVE MEDICAL REHABILITATION PROGRAMS
# FOR
# MARYLAND

MARYLAND STATE PLANNING COMMISSION

August 1961

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SUBCOMMITTEE ON CHRONIC ILLNESS

# COMPREHENSIVE MEDICAL REHABILITATION PROGRAMS
# FOR
# MARYLAND

Publication no. 114

COMMITTEE ON MEDICAL CARE
MARYLAND STATE PLANNING ~~COMMISSION~~ - Dept.

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DEPARTMENT OF PLANNING
AND
PLANNING COMMISSION

STATE OFFICE BUILDING
301 W. PRESTON STREET
BALTIMORE 1, MD.

August 23, 1961

Aaron Deitz, M. D.
Chairman, State Board of Health and Mental Hygiene
301 West Preston Street
Baltimore 1, Maryland

Dear Dr. Deitz:

The State Planning Commission has approved the report from its Committee on Medical Care entitled *Comprehensive Medical Rehabilitation Programs* for Maryland. This study was initiated at the request of the State Board of Health.

We sincerely hope that it will provide the guidance sought by the Department of Health.

Sincerely yours,

James J. O'Donnell

James J. O'Donnell, Director
Planning Department

STATE OF MARYLAND

nes J. O'Donnell
Director
nning Department

rge H. Yeager, M.D.
Chairman
nmittee on Medical Care

Commission

Joseph Meyerhoff
Chairman
James C. Anderson
F. Murray Benson
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E. Homer White, Jr.

DEPARTMENT OF PLANNING
AND
PLANNING COMMISSION

STATE OFFICE BUILDING
301 W. PRESTON ST.
BALTIMORE 1, MD.

May 12, 1961

Mr. Joseph Meyerhoff, Chairman
Maryland State Planning Commission
301 West Preston Street
Baltimore 1, Maryland

Dear Mr. Meyerhoff:

It is my pleasure to submit the report of our Subcommittee on Chronic Illness. This study was initiated by request of the State Board of Health. The subcommittee's report was adopted by the Committee on Medical Care at its meeting on May 12, 1961.

Sincerely yours,

George H. Yeager

George H. Yeager, M.D.
Chairman, Committee on Medical Care

STATE OF MARYLAND

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Director
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Commission

Joseph Meyerhoff
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James C. Anderson
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E. Homer White, Jr.

DEPARTMENT OF PLANNING
AND
PLANNING COMMISSION

STATE OFFICE BUILDING
301 W. PRESTON ST.
BALTIMORE 1, MD.

April 20, 1961

George H. Yeager, M. D.
Chairman, Committee on Medical Care
State Planning Commission
301 West Preston Street
Baltimore 1, Maryland

Dear Dr. Yeager:

It is my pleasure to transmit the report of the Subcommittee on Chronic Illness.

Sincerely,

Allen Voshell

Allen F. Voshell, M. D.
Chairman
Subcommittee on Chronic Illness

# COMMITTEE ON MEDICAL CARE

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Chief, Committee on Medical Care

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## INTRODUCTION

The Committee on Medical Care was asked in 1958 by the State Board of Health to inaugurate a study of the necessary coordination between home care, general hospital care, chronic hospital care, and physical rehabilitation services for the chronically ill of all ages.

Subsequent to this request the report Administering Health Services in Maryland* was issued, providing the guidance sought by the State Board of Health on many of the issues relating to the chronically ill. Unanswered, however, were questions concerning physical rehabilitation services: What additional physical rehabilitation services are needed? Where are they needed? How should they be organized? Under whose auspices? What priorities should be set for the allocation of federal construction funds for rehabilitation facilities? What sort of means test should apply to the rehabilitation program? What agency should be responsible for overall planning? These questions were not quite germane to the inquiry of the Subcommittee on Policies and Financing of Maryland's Medical and Hospital Programs. It is to these items, therefore, that our subcommittee addresses itself.

Rehabilitation, however, is a complex process. Much additional data is needed before any final plan can be developed for rehabilitation services, and a considerable portion of this data will require clinical research and evaluation. There is, however, an indication as to the direction which should be taken in the development of rehabilitation services. Therefore, in answering the questions listed above, it should be borne in mind that our recommendations bear more on the approach to the problem than to a solution.

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*Administering Health Services in Maryland, Report of Subcommittee on Policies and Financing of Maryland's Medical and Hospital Programs, Committee on Medical Care, Maryland State Planning Commission, June 1960.

## CHAPTER I

## SUMMARY OF RECOMMENDATIONS

1. Two comprehensive adult outpatient medical rehabilitation facilities should be established around the existing services at University Hospital and The Johns Hopkins Hospital. Administrative reorganization and a slight augmentation of services should accomplish the goal of the two outpatient facilities without major, or any, capital expense. By affiliation with at least one of the existing inpatient rehabilitation facilities, Maryland will then have two comprehensive medical rehabilitation programs (centers).
2. These comprehensive outpatient rehabilitation facilities should be established as community resources.
3. Continual evaluation as to the further need for rehabilitation facilities should be a prime function of these new outpatient facilities.
4. As a demonstrated need is established for additional medical rehabilitation facilities, they should be organized as community resources, as affiliates of one or more of the inpatient (or outpatient) facilities, and as affiliates of a medical school affiliated hospital.
5. Allocation of construction funds under the Wolverton Amendment to the Hill-Burton Act should be made to comprehensive, medical rehabilitation centers (or for their component outpatient, acute inpatient, or long term inpatient services) and only in rare instances to single purpose centers.
6. The means test employed to determine the ability of patients to pay for part or all of the therapy should be appropriate to the objectives of the program and should not deter patients from obtaining rehabilitation services. Since the programs would be community resources, the care of those

patients who can bear only a part or none of the cost should be financed as a public health responsibility on a State/local sharing basis.

7. The training of additional medical and para-medical personnel should receive high priority attention, since there is a critical shortage throughout the rehabilitation field.

8. The State Department of Health, and through it the local health departments, should be the focal point for coordinating planning and organized efforts directed toward the care of the chronically ill, and should assume leadership in stimulating State and community action to implement the recommendations contained in this report.

## CHAPTER II

## THE REHABILITATION PROCESS

> "In our times we are experiencing the rapid emergence of a new approach to the health and social welfare of injured and disabled persons. This is the concept of rehabilitation. The realization that even the very seriously disabled can be helped to find a useful and respected place in society and that it is our moral responsibility to help them find this place is having a powerful impact upon the professional groups that serve disabled persons and upon the organization of rehabilitation services.
>
> "By introducing a broad concept of human purpose, rehabilitation is uniting many professional fields in a common approach to the problems of disabled people. Increasingly, problems of the handicapped are being viewed as a complex of interrelated problems, each of which can be satisfactorily defined and ameliorated only as it is viewed in relation to all of the individual's needs. Rehabilitation, therefore, is the cement by which various professional approaches to the injured individual are being combined into a constructive, co-ordinated program." *

Traditionally medical rehabilitation has been an essential part of the family practice of medicine. Over the years, however, as the body of medical knowledge has increased, the need for specialties developed, and the family physician's scope of responsibility in all areas (including rehabilitation) became less than it was for the physicians a generation or two before. The more complicated problems are now regularly referred to specialists, particularly in urban areas. In this process of specialty development, however, the total needs of the patient were sometimes lost sight of. Because of this, and because of the complicated condition of a growing number of disabled persons, rehabilitation medicine developed. This new approach was by no means an attempt to usurp the

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*Basil J. F. Mott: Financing and Operating Rehabilitation Centers and Facilities, National Society for Crippled Children and Adults, Inc., Chicago, July 1960, page 9.

normal responsibilities of the family practitioner. To a greater extent medical rehabilitation will always be his responsibility. Rehabilitation medicine as an organized therapeutic approach became necessary simply to handle the more difficult cases.

The rehabilitation process, to be most effective, begins with the initiation of treatment for the injury or crippling disease, and includes preparation of the patient during the acute care period to achieve ultimately the maximum adjustment to, and use of, whatever ability remains.

The rapid development of rehabilitation medicine during the second world war stemmed from the fact that human society was presented with a heretofore unparalled number of war wounded cripples. Medical science and medical art were able to save more lives than in past military conflicts, but with residual disabilities forcing these patients to lead less than full lives. They were the blind, the multiple amputees, the paralyzed, the severely burned. Their prospects for life were less than encouraging. Their ability to earn a livelihood, their ability to satisfy the simple everyday needs of living were severely limited. Some could not work. Others could not walk or feed themselves. Still others were immobile bed cases, unable to communicate, but "alive".

The magnitude of the problem, the sheer press from the number of cases, activated rehabilitation medicine. Something had to be done, and some things were done. It was found that by bringing to bear a variety of medical and social disciplines in a coordinated manner, it was possible to rehabilitate a greater number of the disabled - not always to normal lives, but to a more satisfying level of existence than prospects would have heretofore allowed.

To some patients being rehabilitated meant being able to feed themselves. To others it meant being able to talk, and to still others it meant

being able to live in a wheel chair. To some it meant being able to live at home and to be cared for by one's family. To a few it meant being able to get back to gainful employment - be it in a wheel chair, in a sheltered workshop, or as a relatively normal person.

The monetary cost of rehabilitation, however, is high. A variety of medical specialists are required - neurologists, internists, pediatricians, psychiatrists, orthopedists, surgeons, physiatrists. In addition, many para-medical specialists are needed - physical therapists, speech therapists, nurses, vocational counselors, occupational therapists, and others. Highly skilled personnel, in other words, are usually necessary for each case over a long period of time. In addition, expensive equipment is frequently necessary.

Those returned to gainful employment may become taxpayers. Not only do these conserve state revenues by not staying in the institutions at government expense, but they also - over the years - make sizable contributions to society and the economy via their work and taxes. But more often the rehabilitated just learn to live better with their handicaps - happier, less burden to family and to themselves, perhaps not on the welfare rolls. Here, too, the cumulative savings over the years are considerable. Savings on the welfare dollar, are, however, not all: not occupying a scarce hospital bed, and not commanding the care of skilled personnel who are in short supply - these, too, result in sizable economies.

Rehabilitation, however, is more than economic conservation. It is also one of the marks of a civilized society, an illustration of man rising both to the dignity of man and to evidence a certain reverence for life. Underlying some of the value placed upon rehabilitation may also be the simple recognition that "there but for the grace of God go I, and tomorrow it may well be that I too shall go".

While the war wounded gave rehabilitation medicine its great opportunity, we should not be misled into believing that the war wounded are its sole concern. Physical medicine and rehabilitation is concerned with the handicapped throughout the community - those born with physical disabilities and those who acquire them during the course of living. It is concerned with the ever increasing number of teen-agers who suffer paralyzing neck injuries while diving. It is concerned with the mutilated automobile victims. It is concerned with the neighbor who is paralyzed following a stroke.

## CHAPTER III

## COMPREHENSIVE MEDICAL REHABILITATION PROGRAMS

The Conference of Rehabilitation Centers and Facilities defined "rehabilitation center" in these words:

> A rehabilitation center is a facility in which there is a concentration of services, including at least one each from the medical, psycho-social, and vocational areas, which are furnished according to the need, are intensive and substantial in nature, and which are integrated with each other and with other services in the community to provide a unified evaluation and rehabilitation service to disabled people.*

Rehabilitation centers may offer a variety of services on an inpatient and/or outpatient basis. They may not always be located in the same building or on the same grounds. Existing centers may reflect the needs or attitude of the sponsoring groups - such as a casualty insurance company or an association interested in heart disease, cerebral palsy, mental retardation, or arthritis. Or, a center's services may reflect patient need for certain services, as distinct from the developer's conception of what the center should ideally offer.

Despite the lack of reliable data on need for rehabilitation services we believe that it is possible to outline a plan for the development of services in Maryland. We need, however, to free ourselves from any conceptual limitations imposed by existing local programs.

---

*This definition, the first professional one, was developed in October 1953 by the Conference of Rehabilitation Centers and Facilities at its Second Annual Meeting in Miami Beach, Florida. It is reported by Henry Redkey in Selected Papers, National Conference of Rehabilitation Centers, Second Annual Meeting, October 1953, page 10. (Mott, op. cit. page 9).

Fundamental to any sound definition of a comprehensive rehabilitation center (program) is recognition and acceptance of the interrelatedness of medical services. The point was succinctly made in the Report of the Subcommittee on Organization for Health:*

> "The human body is a complex organism, composed of many systems, each of which inter-acts with the others. Each system, while definable as to its special function - nervous, respiratory, skeletal, muscular, etc. - relates to and depends upon the other body systems. Because of this interrelatedness and interdependence, medical problems should be viewed with an integrated perspective. The patient's total medical needs should be kept constantly in mind.
>
> "Specialist care, essential to the treatment of disease and malfunction in some of the systems, should always relate to the total needs of the body. Otherwise, the individual's medical requirements are fragmented, the systems of the body tending to be treated in special hospitals in remote areas where the organization and mode of practice may not be attuned to the other clinical needs of patients. This leads directly to the social crippling so prevalent in our mental and chronic disease and tuberculosis hospitals today. It leads ultimately to bad medical care, for symptoms in one body system may well indicate a medical problem in some other body system which is normally diagnosed and treated by a different type of medical specialist. We would emphasize that while the lack of attunement to the total clinical needs of patients is a weakness of the special hospital approach, many private institutions have carefully avoided the pitfalls and provide excellent care.
>
> "The importance of an intimate interrelationship between medical specialties cannot be overstated. To maintain a balanced perspective toward an individual's medical care needs and to assure quality in medical services, it is essential that all medical disciplines be closely coordinated, with each specialty's clinical approach constantly available to, and reviewed and challenged by, the medical community.
>
> "Communities have met the need for integrated services largely through their general hospitals. There, the various specialty services (surgical, medical, obstetrical, pediatric,

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*Report of Subcommittee on Organization for Health, Committee on Medical Care, Maryland State Planning Commission, June 1960, page 5.

> psychiatric, etc.) operate in concert with each other under a single board and administrator. Patients being treated in one service find their other clinical needs met from the other services. Consultation and joint treatment are facilitated. Communications are augmented by regular clinical staff conferences. Professional review committees provide regular checks on the quality of care. The organization, in sum, works to maintain an integrated approach to the multiple medical needs of patients. It makes difficult any attempt, or tendency, to fragment patient care.
>
> "To a lesser extent, communities have sought to integrate services further by the development of non-institutional services such as nursing homes, home care programs, clinics, and preventive health programs. It is recognized more and more that an adequate range of services must include these elements, for they can appreciably reduce the need for institutional care, and allow for the earlier discharge of many patients who require some institutional care during the course of their treatment."

This suggests to this subcommittee that a proper rehabilitation center (program) should be multi-disciplined and that it should provide, or offer through appropriate affiliations, a complete range of services on both an inpatient and outpatient basis.

It should be multi-disciplined - providing a wide range of medical services, and also of psychological, social, and vocational services. It should be able to cope with the many different needs of different types of disabled persons. Programs should not be encouraged which exist solely for the rehabilitation of a single disability group, such as heart or cerebral palsy or arthritis. Not only do such single purpose centers lend themselves to an inefficient use of scarce medical talent, but also they run the risk of not being attuned to the total clinical needs of their patients. We would not want to be misunderstood on this point: the single purpose rehabilitation center has done a magnificent job. It was such centers that provided the real clue as to what rehabilitation medicine might accomplish. The sponsors of such centers started without data

and information when no one else was interested or able to do anything. The usefulness of these centers will, however, diminish as their case loads are handled through the yet-to-be-established comprehensive, multi-disciplined programs (centers).

The proper rehabilitation center, as we have indicated, should provide, or offer through appropriate affiliations, services on both an inpatient and outpatient basis. Some cases, to be sure, must be handled on an inpatient basis. But many cases need not be institutionalized; outpatient facilities can easily meet their need for care. Similarly, the existence of outpatient services will permit the earlier discharge of many inpatients. The efficiencies found in a wide range of community and institutional services, suitably coordinated, has been well stated in the report Administering Health Services in Maryland.* Three of the main theses of that report apply to the problem we are considering. They are:

1. The right service, for the right patient, at the right time, in the right place.
2. The period that patients are hospitalized in an inpatient facility should be but an episode in the programmed care of only those patients who need it.
3. The ultimate objective is to keep the patient as closely related to his home and community environment as possible through each step in his programmed care.

The specific services which should be offered by a comprehensive medical rehabilitation program will vary, depending in large measure on the type care

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*op cit.

required by patients. There are some basic elements, however, which can be anticipated either on a full time or consulting basis:

> Diagnostic and evaluation service. This unit would screen all patients at intake. Some it would accept for rehabilitation; others it would reject. Participating in this phase of the program would be the key units which would provide the various services if the patient is accepted for treatment - medical, psychological, social, and sometimes vocational. This service would be coordinated under the direction of a competent physician, as would all of the medical, psychological, social, and concurrent vocational services. It would, in addition, periodically evaluate the progress of the various patients under treatment at the center. Under the direction of a physician, who may be the medical director, this unit would function as the over-all coordinator. It would determine not only admissions, but also the desired therapy, changes in therapy, and the readiness for discharge. The medical director would supervise and carry out the medical services for those patients accepted for rehabilitation. A variety of medical and para-medical specialists would be available - either full or part time - to serve the multiple medical needs of the patients.

Redkey in his book Rehabilitation Centers Today* defined some of these medical services. All, we believe, are essential to a proper rehabilitation center:

> Medical Consultation: The availability, on call, of appropriate medical specialists for consultation with medical personnel of the center on specific cases.
>
> Psychiatric Screening: Examination by a psychiatrist to determine whether there is mental and/or emotional involvement affecting the rehabilitation program and, if there is, to recommend how these problems should be handled in relation to the patient's rehabilitation program.
>
> Medical Supervision: Actual oversight and control on the premises of all medical aspects of the rehabilitation program, by a physician licensed to practice medicine or surgery. Includes prescription for medical services, and the direction of medical therapies such as physical and occupational therapy.......
>
> Physical Therapy: The administration of medically prescribed activities and procedures utilizing the restoration properties of physical agents and exercises to correct or alleviate disabilities resulting from neuromuscular or orthopedic dysfunction, in order to develop the patient's functional capacities to the greatest degree possible. Performed by registered physical therapists.

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*Henry Redkey: Rehabilitation Centers Today, Office of Vocational Rehabilitation, U. S. Department of Health, Education, and Welfare, 1959, page 33f.

Occupational Therapy: The administration of medically prescribed activities utilizing creative, manual, and industrial arts, media, and techniques, designed to assist in the physical and mental restoration of disabled persons. Performed by registered occupational therapists.

Speech Therapy: The instruction and supervision of patients in exercises designed to help them overcome deficiencies in speech resulting from any type of disability. May include speech pathology for the diagnosis of speech disorders. Usually practiced by trained therapists and sometimes, but not always, under medical supervision.

Audiological: The services of audiologists in diagnosing and treating deficiencies in hearing and the results thereof, including the prescription of prosthesis, lipreading, auditory training, and speech correction and development.

Recreational Therapy: Activity of a recreational type, under medical supervision, intended to benefit the patient physically, socially, or emotionally.

Redkey* defines other services which this subcommittee agrees should be an integral part of any comprehensive rehabilitation service. They should, we would emphasize, be correlated under medical direction with the diagnostic and evaluation service, as well as with the medical services.

Psychological Evaluation: The service of a psychologist in testing and evaluating skills, aptitudes, interests, and

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*ibid., page 41f.

other psychological factors in making an estimate of the disabled persons rehabilitation potential.

Personal Adjustment Counseling: The services of a psychologist in helping a disabled person to understand, accept, and remedy conditions or attitudes which interfere with his rehabilitation. Performed in consultation with or under supervision of a psychiatrist.

Group Therapy: The practice of counseling with several individuals at one time to improve their functioning in rehabilitation, with the purpose of taking advantage of group interaction.

Special Evaluation: The collection of information of a social nature from the disabled person, his family, and others, and the appraisal of such information to draw conclusions regarding the disabled person's rehabilitation potential.

Social Casework: The process of working with individuals to facilitate their rehabilitation through solution or amelioration of problems growing out of their relationships to others, particularly those most influential in his social environment. Practiced in centers by trained social workers, often medical social workers, and sometimes by psychiatric social workers.

Social Group Work: The practice of using planned group activities for the purpose of furthering social adjustment. Sometimes practiced in centers by trained social group workers and sometimes not.

Recreation, Non-Medical: The provision of recreational and diversional activities for the constructive use of leisure time to build morale, to measure socialization, and to introduce the elements of community living.

Vocational services should also be an integral part of a comprehensive medical rehabilitation program. Since many patients can benefit from simultaneous medical and vocational therapy, the latter should be provided in close proximity to the medical facilities, and be suitably coordinated with medical supervision. We would emphasize our inclusion of "vocational services" as distinct from a "vocational rehabilitation center". The advisability of a vocational rehabilitation center, operating independently of a medical rehabilitation center, is something which would have to be studied carefully, though in this subcommittee's opinion there is some doubt as to the wisdom of such an independent approach. In the event of its creation, however, the need for comprehensive services would by no means be obviated.

## Present Medical Rehabilitation Services in Maryland.

Long term inpatient rehabilitation services are presently available at Baltimore City Hospitals, Montebello State Hospital, Western Maryland State Hospital, Deer's Head State Hospital, and the Veterans Administration Hospital (Fort Howard). Limited inpatient rehabilitation programs exist at The Children's Hospital and Kernan Hospital (both restricted to orthopedics), at Levindale, and at the Children's Rehabilitation Institute for Cerebral Palsy.

The need for a long term inpatient facility in the Washington metropolitan area will probably develop in the near future. This can be anticipated simply because that area has a large enough population to require such services in the vicinity. Rehabilitation, it needs to be emphasized, is not a

problem of old age but rather of all ages, as demonstrated by the fact that at Montebello State Hospital the average patient age of those undergoing rehabilitation is about the same as the average patient age in a large general hospital (when one excludes the pediatric cases which Montebello does not handle).

Additional inpatient expansions within the State's chronic disease hospital system can also be anticipated if the inflated case loads, cited in the recent report Administering Health Services in Maryland*, are not reduced. Prolonged hospital stays by patients who should be at home or in nursing homes may well force the construction of additional hospital facilities. To a large extent patients are in the chronic disease hospitals beyond the period necessary because the communities have failed to develop the needed local services to care for their citizens, nursing home care in particular.

When it comes to outpatient rehabilitation facilities and services we find a somewhat disjointed picture throughout the State. Outpatient rehabilitation services, integrated or affiliated with inpatient services exist, only at Montebello State Hospital, University Hospital, and Baltimore City Hospitals. Levindale is developing in this area. Montebello limits its outpatient services, however, to former inpatients and to a few awaiting admission as inpatients. Some patients are also treated at The Children's Hospital and Kernan Hospital. The Children's Rehabilitation Institute for Cerebral Palsy accepts outpatients who have cerebral palsy. Other services - physiotherapy, home nursing care, medical consultation, etc. - are available on a non-organized basis through individuals and various community agencies.

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*op cit.

Local health departments are perhaps more deeply involved in outpatient services and in diagnosis and evaluation than one would at first suspect. Their diagnostic procedures and evaluations, however, are usually done on a categorical basis - that is, by team visitation to their various specialty clinics, except under Crippled Childrens' Services when the multi-disciplined diagnostic and evaluation centers at University Hospital and The Johns Hopkins Hospital are utilized.

The Johns Hopkins Hospital has a wide range of rehabilitation services, but they are not coordinated at this time to function as part of a rehabilitation center. The hospital maintains two units, however, which do function as core units for a comprehensive rehabilitation program. These units are the Diagnostic and Evaluation Center for Handicapped Children, and the Adult Evaluation Clinic, both of which were started in cooperation with the State Department of Health. There are plans for coordinating the program and services of the Children's Rehabilitation Institute for Cerebral Palsy adjacent to The Johns Hopkins Hospital. When this is accomplished, complete inpatient and outpatient services for disabled children will be available through The Johns Hopkins Hospital and its affiliates. The potential for an adult rehabilitation center exists, and could be developed around the Adult Evaluation Center, since appropriate inpatient affiliations exist with Baltimore City Hospitals, and informally with Montebello State Hospital.

University Hospital is rapidly moving toward the establishment of a comprehensive rehabilitation program under the direction of the Department of Preventive Medicine and Rehabilitation. Plans also call for setting aside a small number of acute inpatient beds to handle patients awaiting admission to Montebello or Baltimore City Hospitals, and to serve as a short term (less than 30 days) inpatient rehabilitation service. The University rehabilitation center

becomes complete through its affiliation with Montebello and Kernan Hospital. (University Hospital at present has three diagnostic and evaluation services: the Diagnostic and Evaluation Center for Handicapped Children, the Adult Evaluation Clinic, and the Work Classification Unit.)

There has been some interest shown in developing rehabilitation services in two other Baltimore hospitals, one of which, Maryland General, has appointed a committee to study the need and feasibility of such a step.

The more rapid development of outpatient rehabilitation services is dependent upon further education of professional and lay people as to the aims and achievements of this program. The development of outpatient services is further hampered by the high cost of medical rehabilitation. The per visit cost to a rehabilitation facility, while perhaps only $5 in many cases, may easily run up as high as $25 per visit, depending on the services required. Allowing five visits per week for a three or six month period, one can appreciate how costly rehabilitation can be. The high cost of being medically rehabilitated in part accounts for under-utilization of centers in other states.* In Mott's study of ten centers, inpatient centers required an average operational subsidy of 18%; outpatient centers required an average operational subsidy of 63%. This has been a damper on the development of centers. The dilemma looms large

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*Another factor in under-utilization is, of course, the lack of professional and public knowledge as to what services are available and what can be done for the disabled. One industrial firm in Maryland, for example, will send its disabled employees out of the State, rather than to Montebello. Their reasoning is that some of the better known centers are better able to cope with the disabled - better equipment, more intensive care. This subcommittee would contest that point, and suggests that some simply have not kept up with what Montebello has to offer.

in the eyes of potential developers: how, after all, can a center survive economically if the cost of rehabilitation is so high as to deter those in need of rehabilitation?*

A third factor which hampers the development of rehabilitation services is an acute shortage of trained personnel. This can be accounted for both by the newness of rehabilitation medicine and by the lack of information concerning rehabilitation on the part of the medical, hospital, and allied professions. The medical profession, in this regard, has a responsibility for teaching comprehensive medicine in graduate and undergraduate programs.

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*Mott, op cit., Table 1, page 20. It should be noted that Mott and others refer to "inpatient centers" and "outpatient centers". We have carefully tried to avoid such reference. To this subcommittee a proper rehabilitation center offers comprehensive services on both an inpatient and outpatient basis. To the components of a comprehensive rehabilitation program we append the names "inpatient facilities" and "outpatient facilities". The components of a program (center) need not, moreover, be located in the same building or on the same grounds.

# CHAPTER IV

## RECOMMENDATIONS

1. Two comprehensive adult outpatient medical rehabilitation facilities should be established around the existing services at University Hospital and The Johns Hopkins Hospital. Administrative reorganization and a slight augmentation of services should accomplish the goal of the two outpatient facilities without major, or any, capital expense. By affiliation with at least one of the existing inpatient rehabilitation facilities, Maryland will then have two comprehensive medical rehabilitation programs (centers).

Chronic disease trends indicate that at least two comprehensive, multidisciplined, adult outpatient medical rehabilitation facilities will be needed in the Baltimore area to complement the services available at the inpatient facilities. An orderly development toward meeting this need should be undertaken. The need with regard to children has been under study by the Subcommittee on Medical Services and Facilities for Handicapped Children; there would appear to be well developing rehabilitation programs in this area.

In view of the high cost of construction and operation, and of the shortage of trained personnel, these first programs should utilize to as great an extent as possible existing facilities, services, and personnel. In other words, until these initial programs prove themselves there is no need to place the inpatient and outpatient facilities on the same grounds or under the same administration, nor is there need to construct new facilities and hire from other institutions personnel already in short supply.

The core unit for a rehabilitation program is the diagnostic and evaluation service. Both University Hospital and The Johns Hopkins Hospital have such services. Both institutions also have a wide range of existing outpatient services which can be tied into comprehensive rehabilitation programs. In part, because of this, we recommend the organization of the outpatient programs at those institutions. (The service at University Hospital is, in fact, almost operational

under its Department of Preventive Medicine and Rehabilitation.) Another important factor behind our recommendation is that both hospitals are medical school affiliated, and there is a great need to augment teaching of comprehensive medicine, as well as to encourage research in this field. It is recommended that both University Hospital and The Johns Hopkins Hospital be formally affiliated with inpatient rehabilitation facilities - University with Montebello State Hospital and Kernan Hospital, Hopkins with Baltimore City Hospitals. These affiliations should facilitate the desired relationship between the several inpatient and outpatient facilities to encourage patient flow to that facility and service most suited to patient needs; given this, Maryland will have truly comprehensive medical rehabilitation programs (centers).

The development of these outpatient services should not preclude existing pre- and post-admission services at the inpatient facilities (for example, as now exist at Montebello and Baltimore City Hospitals), the eventual development of outpatient programs on the grounds of the inpatient facilities (for example, at Montebello and Baltimore City Hospitals), or multiple affiliations (for example, Montebello with University Hospital and The Johns Hopkins Hospital). Nor should the affiliation with the long term inpatient facilities preclude the development of an acute inpatient rehabilitation service in conjunction with the outpatient service or with an affiliated general hospital (for example, the planned acute service at University Hospital). These adult programs should be suitably coordinated as required with those available for children to maximize the potential of services, personnel, and facilities.

We would wish to emphasize that in any of the proposed comprehensive rehabilitation programs, vocational rehabilitation services can and should play a significant role. This role can be fulfilled, however, only if the vocational services are suitably coordinated with medical services.

2. These comprehensive outpatient rehabilitation facilities should be established as community resources.

As such they should work closely with local health departments, local hospitals, and various community agencies. As qualified personnel become available, diagnostic and evaluation teams should periodically go out from the facilities and screen cases in local health departments, general hospitals, and nursing homes. Quick access to potential rehabilitation cases in general hospitals is essential to a successful rehabilitation program and should be arranged between the hospital and the outpatient rehabilitation service. Rehabilitation begins, properly, on admission for acute care. Those cases which are to become rehabilitation cases - on an inpatient or outpatient basis - should be worked up by the outpatient services for they will be equipped to move into the facilities of general hospitals. In some instances, moreover, it would be advisable for the outpatient service to provide an acute, short term inpatient therapeutic program in the setting of the general hospital. Diagnostic and evaluation teams which penetrate community hospitals and health departments will, in addition, be educating people on what the rehabilitation process is.

3. Continual evaluation as to the further need for rehabilitation facilities should be a prime function of these new outpatient facilities.

A waiting list should be established at each facility. This will provide a partial indication as to the extent of need and willingness to satisfy that need. (In using a waiting list, admissions from it should be based not on the person's numerical standing, but rather on his rehabilitation potential.) Many of the research projects will end up by adding patients to the waiting lists. For example, it would probably be quite fruitful for diagnostic and

evaluation teams to screen patients now resident in nursing homes and mental hospitals. (To some small degree Montebello now does this in cooperation with Spring Grove and Springfield state hospitals.)

The need for additional rehabilitation programs will, we are confident, develop. The question is when will the need exist? Also, where will it exist? Will the need be primarily for inpatient or outpatient services? In view of costs and personnel shortages, crash programs would be rash. Primarily research, and in particular clinical evaluation, will determine the "when" and "where" and "type of service". We would stress the importance of clinical evaluation, and we caution against short cut methods. Representative population samples, clinically evaluated, will give fairly sound results, though even here one must not jump to the conclusion that a patient will undergo the treatment he needs. On the other hand, rehabilitation surveys which are not based on clinical evaluation should be viewed with appropriate caution. Such surveys are common. They are usually based upon health questionnaires and/or household interviews. They yield impressive results, but not too reliable data on rehabilitation potential. In fairness to the survey method, however, it might be noted that this technique can be fairly reliable in locating the disabled. By this method one cannot tell, of course, whether or not the disabled will avail themselves of rehabilitation if the services are available. They may speak with good intent, as does the man who plans for two years to be innoculated against polio, but just never gets around to getting the shots. It is a somewhat doubtful venture to develop major programs on a reported willingness to seek care. The fact remains that the only valid test is clinical diagnosis and evaluation, followed by actual rehabilitation. To do the former without rehabilitation will give rise to a projection as to need without knowing whether or not the persons will in fact seek out the services once they are established. For these reasons, additional facilities and centers should be developed with care.

4. As a demonstrated need is established for additional medical rehabilitation facilities, they should be organized as community resources, as affiliates of one or more of the inpatient (or outpatient) facilities, and as affiliates of a medical school affiliated hospital.

The rendering of outpatient or inpatient rehabilitation services is an episode in the programmed care of disabled patients. As such each service must facilitate, and not hamper, the flow of patients to and from the facility and service most suited to their needs. Additional facilities, therefore, should develop within the framework of community needs and as part of a comprehensive medical rehabilitation program, and not on a categorical basis. Prime areas for actual development of outpatient services are the larger general hospitals and the State's chronic disease hospitals. Thought along these lines by these institutions and their assistance in the research projects will speed the day when our needs are more fully recognized and met. In particular, Montebello and Baltimore City Hospitals should consider such outpatient programs.

Reference has been made to the probable need for inpatient rehabilitation facilities in the Washington area.* This should be studied specifically by the State Department of Health and the facility planned, either as a voluntary or State service. To advance the objectives delineated in the Report of the Subcommittee on Organization for Health**, this facility should be planned as part of, or in close proximity to, an acute general hospital.

5. Allocation of construction funds under the Wolverton Amendment to the Hill-Burton Act should be made to comprehensive, medical rehabilitation centers (or for their component outpatient, acute inpatient, or long term inpatient services) and only in rare instances to single purpose centers.

A "rare instance" would exist only when it can be demonstrated that it is not practicable, from a medical viewpoint, to utilize the services of a compre-

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**op. cit.

hensive center. At this juncture in research a mental retardation center would be an example of a center such as to warrant support of a single purpose facility, though even it might utilize some of the services of a regular, multidisciplined program - in particular, the diagnostic and evaluation service. Conceivably in two or three decades, following appreciable advances in research, the propriety of separating mental retardation may no longer exist. Funds for rehabilitation programs, particularly for those not herein mentioned, should only be allocated after there is a reasonable basis for believing that the facility will be necessary and solvent.

6. The means test employed to determine the ability of patients to pay for part or all of the therapy should be appropriate to the objectives of the program and should not deter patients from obtaining rehabilitation services. Since the programs would be community resources, the care of those patients who can bear only a part or none of the cost should be financed as a public health responsibility on a State/local sharing basis.

Rehabilitation is costly. As indicated elsewhere in this report, the outpatient per diem cost may run as high as $25, and the rehabilitation process to be most effective may require care five days a week for many months. The inpatient facilities are even more expensive. While the reported cost in a State chronic disease hospital is only $13.82 per day, if one would exclude the nursing home and terminal types of cases from the computations, the cost of the rehabilitation patient may well be more than $13.82.

Very few people can afford the high cost of rehabilitation, yet it is essential that rehabilitation be started as soon as possible. Delays for financial reasons make the rehabilitation process much more difficult, since the disabled person's condition tends to become more permanent and/or more serious the longer therapy is delayed.

A reasonable alternative to government subsidy of this service would be its inclusion under voluntary health insurance programs. At this time, however, this is not possible, though given adequate data on experience, the rate structure of voluntary health insurance programs could be suitably accommodated to include this type of care. We believe that studies should be undertaken in this regard by Blue Cross and Blue Shield. We do not believe, however, that the development of rehabilitation services should be delayed. For this reason we believe that the centers should be initiated and financed on a State/local sharing basis, with full or part payment by those patients able to pay. Until such time as an acceptable State/local sharing method is developed, it may be necessary for the State to finance these services.

We would caution against too severe a means test. The purpose of these programs is not to make money or necessarily to be self-supporting. Their prime purpose is to rehabilitate the disabled and to keep as many patients as possible at their normal economic and social level. A heavy price for rehabilitation may well deter patients from seeking this service. In this regard Mott* observes:

> "Apparently many, if not most, of the centers studied were not being fully utilized and thus probably were overstaffed at the time of the study. The wide variation among the centers in the proportion of time spent by staff in giving direct service to patients, in the same types of departments, strongly suggests this. Many of the centers' departments could have given more service without increasing staff, and would have, had there been a greater demand for their services.
>
> "That many well-known and highly regarded rehabilitation facilities probably were not being fully used in the attack on disability suggests that this may be true of many other centers. One question raised by this possibility is whether the problem of paying for services adversely affects referrals and, consequently, utilization of the nations' rehabilitation facilities."

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It has been suggested by some that the present means test for care in a chronic disease hospital is such that most who pay part or all of the cost of care are, in addition to being rehabilitated, being pauperized. To illustrate this point, a family of three is "able to pay" all monies earned over $3,540, up to the cost of care. The cost of care for a year at Montebello is $4,975. Thus, for a person hospitalized one year, the charge would be all monies earned over $3,540 up to an income of $8,515 ($3,540 + $4,975). The soundness of this as an index of "ability to pay" is doubtful.

The subcommittee believes that because of the high cost of rehabilitation services for some patients, the means test should be appropriate to the objectives of the rehabilitation program and not deter patients from obtaining rehabilitation services. Since many of the patients in the chronic disease hospitals are either of the nursing home variety or terminal cases, a separate means test might be employed for them.

7. The training of additional medical and para-medical personnel should receive high priority attention, since there is a critical shortage throughout the rehabilitation field.

Some shortages are the result of the "newness" of rehabilitation (there are, for example, only five physiatrists in the State), while some shortages exist because of the inadequate training facilities and personnel practices. A careful study as to the needs within the various medical and para-medical areas, and of steps to meet these needs, is essential for the long term development of rehabilitation medicine.

8. The State Department of Health, and through it the local health departments, should be the focal point for coordinating planning and organized efforts directed toward the care of the chronically ill, and should assume leadership in stimulating State and community action to implement the recommendations contained in this report.

The State Department of Health has been the leader in rehabilitation medicine for Maryland. It operates three outstanding inpatient rehabilitation facilities. It provided the needed support for the diagnostic and evaluation centers at University Hospital and The Johns Hopkins Hospital. It was sufficiently concerned with the State's needs to request this study. It would seem only logical to recommend that that department be the focus for coordinating planning and services. The appointment of an advisory council would, in addition, greatly assist the staff in performance of its duties.

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